Jurisprudence, by Dr. Moeli. Halle a/Saale, Muhlweg 26: C. Marhold.

The Principles of the Comparative Laws for Lunatics, by Dr. Wyler. Halle a/Saale , Muhlweg 26: C. Marhold.

Annuaire de L'Internat en Médecine des Asiles Publics d'Aliénés, 1924. Paris: Vigot Frères.

L'Aliéné et les Atiles d'Aliénés au point d'une Administratif et Juridique, by Dr. Julian Raynier and Henri Beaudorien. Paris: Librarie le Francois.

Summaries of State Laws relating to the Insane. New York: National Committee for Mental Hygiene.

Mental Diseases: A Public Health Problem, by Dr. J. V. May. Boston, U.S.A.: Richard G. Badger, 1922.

Insanity and Law, by Dr. H. Douglas Singer and Dr. William O. Krohn. Philadelphia: P. Blakiston's Son & Co., 1924.

Part II.—Reviews.

The Ninth and Tenth Annual Reports of the Board of Control for the Years 1922 *and* 1923. [1]

Although we have been unable hitherto to comment on the Board of Control's reports for 1922 and 1923 we have by no means been unobservant of the Board's doings. Many pages of the last and the present volumes of the Journal have been devoted to the consideration of the reports of special committees, appointed either by the Minister of Health or by the Board, on matters of great importance in regard to the administration of mental hospitals and the care and treatment of the mentally afflicted, and this very largely has exhausted the space which could reasonably be allotted to the Board's activities.

In our previous review we expressed some concern as to the future of the Board, and whether it would survive the close scrutiny and, in many respects, unfair and prejudiced criticism then being directed to every aspect of our lunacy administration. The *finale* has been the appointment of a Royal Commission on Lunacy and Mental Disorder (England and Wales), and it is the hope of the Association that one outcome will be the strengthening of the Board, especially in medical personnel, and generally in regard to its power to enforce its views on matters touching the care and treatment of the insane. In this number is published the *précis* of the Association's evidence before the Royal Commission, in which are incorporated the Association's views as to a reconstructed Board under the name of "The Board of Mental Health." For years the Board's work has been handicapped by disabilities which we need not repeat (our pages have rendered them

[1] See note, January number, 1923, p. 99.

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familiar to our readers). Nevertheless, the Board can again be congratulated on some really profitable work during the years under review and since, which we must confess seems very largely due to the surprising capacity shown by individual Commissioners for handling many diverse matters at the same moment, and to their tireless energy and their absolute devotion to the cause of a better lunacy service. Such exhausting work would not be called for if the Board were properly constituted. The sympathy, encouragement and inspiration of the Chairman—Sir Frederick Willis—are undoubtedly a great asset to the Board, and of which there is unmistakable evidence in these Reports. On his personal initiative the first Lunacy Conference was called on January 19–20, 1922, which we venture to think was one of the most important departures in the history of lunacy administration, and we dealt with this fully at the time (*vide* April number, 1922, p. 175). This departure has been repeated recently, and two conferences, one on the Report of the Committee on Nursing, and the other on Accommodation, etc., were held at Burlington House, Burlington Gardens, W. 1, on April 21 and April 22, 1925. At the moment we are unable properly to apprise the value of these latter gatherings. The room selected for these assemblies was the worst we were ever in, both in regard to seeing and hearing, and it was rare that we heard a speech right through from beginning to end. Our impression is that when the proceedings are published they will be found to contain much information of the greatest value to medical superintendents and mental hospital Committees, and we await their issue with the greatest interest.

We have already dealt with the reports of the three Departmental Committees on Diet, Nursing, and Records respectively, which were appointed by the Board in 1922 (*vide* October number, 1924, p. 612; April number, 1925, p. 289). As to the Departmental Committee which became known as "Sir Cyril Cobb's Committee," we commented at length on its report (*vide* January number, 1923, p. 90), and the Board's comments on the Committee's recommendations we duly published in the Journal (*vide* April number, 1923, p. 272). None of these matters now call for further comment, but germane to the subject of the latter Committee as appendixes to the Board's report for 1922 are the reports of the Commissioners' inquiries into Dr. Lomax's allegations regarding happenings at Prestwich Asylum, and also into the allegations made by an ex-patient while detained at Long Grove Mental Hospital. The disgruntled people behind these attacks on our lunacy administration have no reason to complain that their allegations were not sifted to the bottom—and through a very fine sieve too—which is very characteristic of the Board's investigations.

The Board only make a passing mention of the Mental Treatments Bill of 1923, in their report for that year, but it is well known that the Bill was very largely the outcome of the first Lunacy Conference, and therefore the Board's connection with many of the proposals contained in the Bill must have been a close one.

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However much we regretted the enforced abandonment of this Bill, we hope soon to see a revised and better edition on the Statute Book, and we feel sure that the Commissioners will continue their strivings to this end.

LUNACY.

Number of notified insane.—The number of notified insane continues to rise, the increase for 1922 being 2,565, which was very near the annual average for the decade immediately preceding the war. The increase during 1923 rose to the high figure of 4,055—the largest ever recorded. These annual increases may be explained on suppositions other than an increased incidence of insanity. We have our own views on the matter, but seeing that it is to be the subject of further comment by the Board in a future report a few comments will suffice now.

The man in the street naturally asks why the insane continue to accumulate, notwithstanding a rising expenditure in housing and skilled treatment and the operations of the Mental Deficiency Act. There is a tendency to forget now-a-days that one wholesome function of the Lunacy and Mental Deficiency Acts is the segregation from the public of those who, by reason of mental disorder or defect, impair the social machine by their inefficiency as citizens, and that the more thoroughly this is done the better for the home and for the nation.

Until we are in a position, financially and otherwise, to cure mental disease more extensively (and it will be an expensive matter, involving many factors other than indoor treatment of a mental hospital), we must continue to carry out an essential duty to the community by acting as guardians to the insane we cannot cure. We thus reduce the intensity of many other costly social problems. In the majority of cases the private care of the chronic lunatic is but a poor substitute for institution care, and unless there is exceptionally suitable environment, the proper place for such a person is undoubtedly a mental hospital or home.

As regards the Mental Deficiency Act, its operations are not as yet extensive enough to have much effect on the number of notified insane, and before this Act can really effectively touch the problem it was designed to solve, the biological fact must be recognized that inherent mental defects of the most serious kind sociologically do not show themselves until one of the basic instincts of human character, that of reproduction, becomes active during puberty and early adolescence. We have enlarged on this point before, and trust it will not be forgotten when the Act comes to be revised.

"*Rate-aided*" *and not* "*pauper patients.*"—We are unfeignedly glad to note that, in the 1923 report, the Board announces its intention for the future to style those patients who are either wholly or partly maintained by the Poor Law Authorities as "rate-aided" and not "pauper." This is one of the recommendations of the Association, and its natural corollary is the severance of the Poor Law and the care and treatment of the destitute and indigent insane. It is the indigent who are most hardly hit by needing, in the first

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instance, to apply to the Poor Law and become pauperized before they can be treated within the law for mental afflictions. Although the severance is greatly to be desired, it will be difficult of achievement unless the Poor Law Authorities are abolished, and in the main their functions taken over by public assistance committees of the county and borough councils. There is no reason, however, in the meantime why this stigma should be emphasized by classifying such cases in mental hospitals as "pauper."

Voluntary boarders.—In our last review we commented at length on some aspects of this category of mental patient, especially as regards regularization of the formalities in connection with admission, discharge and, when necessary, certification. Since then another category of mental patient was envisaged by those who drafted the Mental Treatment Bill of 1923, namely the "non-volitional." The difficulty arose at once of clearly defining the meaning of the new term. The case cited in our last review and the query we put as to its disposal, etc., was one in point. Briefly, we asked, could a patient, who was admitted voluntarily and who, say, developed acute confusion, in which mental state he could not take advantage of his voluntary status and claim his discharge, be retained without certification? We doubted it. Under the Mental Treatment Bill he could be dealt with under Section 4 and certification avoided. We think that a non-volitional case, whether admitted so or becoming so afterwards, should be notified to the Board as representing the legal authorities. The Board should act as guardian by periodic inquiries, and visitation if necessary, until a satisfactory disposal be effected.

An intricate point has been raised as to whether a mentally afflicted person can legally sign a contract to dispose of himself as a voluntary patient. The present Lunacy Acts speak of "boarders" not "voluntary boarders," and, as regards licensed houses, a person who is not in any way mentally disordered can become a voluntary boarder if he is a relative or friend of a boarder. Licensed houses can therefore receive two types of boarders, and in both cases official consent must be sought by the boarder himself. There is no actual contract but an application for admission to a mental institution and a "consent" thereto by those authorized by the Lunacy Act to give it. However, the law recognizes that a voluntary patient mentally afflicted can demand and obtain his discharge, and it follows that it cannot reasonably deny the legality of his demand for admission. As we have said before, the simpler the formalities of admission the better. The only grounds we know of for official consent to be required before a voluntary patient can be admitted is to make sure whether he is or is not a certifiable patient.

Why "consent" is required in the case of a sane boarder we cannot imagine, except that perhaps such a case was thought to be still more suspicious as regards certifiability. In any case, the Association thinks that, in these days, such consent is no longer required.

The total numbers of voluntary boarders admitted to registered

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hospitals and licensed houses during 1922 and 1923 were 400 and 420 respectively. The figure for 1901 was 273. To these must be added 452 admitted to the Maudsley Hospital during the year ending January 31, 1925. As regards the former, the demissions by certification were, during 1922, 54, and 1923, 77. During 1922 one voluntary boarder committed suicide, and during 1923 no less than three, which does not point to there being any hurry to effect certification.

Admissions, discharges and deaths.—We continue our brief reference table regarding these. For purposes of comparison those for 1921 are reproduced:

Total direct admissions:

	1921.		1922.		1923.	
Males	10,412	22,740	10,353	23,125	10,310	23,054
Females	12,328		12,772		12,744	
First admissions	18,584		18,844		18,934	
Discharges "recovered"	7,394		7,467		7,295	
Recovery rate on direct admissions:						
Males	28·08%	32·52%	29·12%	32·29%	28·69%	31·64%
Females	32·26%		34·86%		34·03%	
Discharges "not recovered"	3,554		3,508		3,338	
Total deaths	8,543		9,391		8,355	
Death-rate:						
Males	9·35%	8·37%	9·98%	8·99%	8·68%	7·71%
Females	7·59%		8·21%		6·95%	

The admissions during 1922 were the highest recorded for any year except 1914, when they were about 100 more than in 1922. The ratio of admissions to the population has been practically stationary during the past three years, *i.e.* about 6 per 10,000.

The absolute discharges from reception orders (recoveries, relieved, etc.) were for 1922 47·5 *per cent.*, and for 1923 46·25 *per cent.* of the direct admissions.

The death-rate of 7·71 *per cent.* for 1923 was the lowest ever recorded.

From a causes of death table given in the report for 1923 we gather that 1,062 men and 241 women, total 1,303, succumbed to general paralysis out of a total of 8,851 deaths (males 4,330, females 4,521).

Malarial treatment of general paralysis.—Although much preoccupied with administrative matters, many of them the outcome of a wildly directed agitation for lunacy reform and others in connection with lunacy legislation, the Board has found time to interest itself with new modes of treatment of insanity, the most outstanding during recent years being the malarial inoculation treatment of general paralysis, which is widely extending. Dr. C. Hubert Bond, the Senior Medical Commissioner, at the Quarterly Meeting of the Association held in Edinburgh on February 19, 1925, said that the attitude of the Board was one of friendly and interested

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watchfulness, with a great desire to keep in touch with it. So many general paralytics thus treated were remaining at home without relapses that the Board might not be able to remain quiescent on the matter. Even if in a big percentage, like 25 or more, a quasi-convalescence could be produced, it was surely a good step in advance.

In February, 1924, the Board issued a circular letter on the subject indicating the rules recommended to be carried out in connection with the new line of treatment (*vide* our October number, 1924, p. 327). In the report for 1923 a page or so is devoted to the same subject. The incidence of general paralysis for the years 1878 to 1914 inclusive was 12·8 *per cent.* for men and 2·6 *per cent.* for women on the total direct admissions. For the three years 1920–22 the average incidence for men was 10·7 and 1·5 for women similarly calculated—a remarkable drop, especially as regards women. Up to recently there was no effective treatment for general paralysis, so the cause of this decline must be sought in other directions. The Commissioners suggest (*a*) correct diagnosis, (*b*) more early diagnosis and effective treatment of syphilis.

One aspect of the effects of this new treatment is that many cases of general paralysis may be improved mentally, but only so far as to become good institutional working patients, with the result that there would be a lower male death-rate and an increase in the number of notified male insane. Such cases would need some form of special observation, and might call for the creation of colonies for convalescent general paralytics on the lines of colonies for epileptics.

Out-patient treatment of mental disorders.—This is a matter very largely linked up with the indoor treatment of voluntary patients suffering from mental disorders. Our view is that the one is supplementary to the other, and that treatment as an out-patient is, in very many cases, more likely to be successful after a few days in bed for rest and quietude, and especially for observation and examination. Until the public generally are educated to apportion the blame for many common ailments and abnormal feelings to a failure of neuro-psychic processes and not to bodily disease, they are not likely to apply to mental out-patient departments of general or mental hospitals for treatment without some pressure or persuasion. Our experience is that no person resents the suggestion that there is something wrong with his mind and nervous system as the person just on the verge of a serious mental breakdown. The suggestion of such a thing is taken as an insult and the situation calls for delicate handling. From one point of view it is right that this should be so, for nothing is more likely to sap the stamina and courage of a nation than an over-consciousness of nervous and mental processes on the part of its citizens. To blame the mind for every ill flesh is heir to is the effect of the operations of an over-pushful mental hygiene organization, and on the whole it is perhaps better that a community should not know that it has any mental processes or nerves at all than to become hypochondriacal and neurasthenical.

Mental hygiene education requires to be carefully carried out, and

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though best undertaken during the later periods of the ordinary education of children at school, such instruction for adults can be expected to radiate from clinics and out-patient departments of general and special hospitals. Our National Council for Mental Hygiene is alive to this method of cultivating mental hygiene, and for this and other reasons strongly advocates the clinic treatment of early mental cases. However, until something very definite in these directions is undertaken it is not to be expected that the person suffering from exhaustion confusion, hallucinations, anxiety states, mild affective disturbances, failure of memory and capacity for work, etc., will knock at the door of an out-patient mental department for treatment, and still less clamour for admission to a mental institution or mental wards of a general hospital. That there should be such out-patient departments attached to every general hospital and infirmary, or associated with the district mental hospital, cannot be questioned, especially as regards the former. The early mental case, if at all cognizant that there is something wrong with him, puts his complaint down to a physical cause, and promptly takes it to a general hospital or infirmary or consults his doctor. It is at this stage that the first failure occurs. The mental origin is not recognized. The second failure is that if it be recognized, there is no mental department or specialist to refer the case to. It is thus allowed to drift or is wrongly treated, and, after a longer or shorter time, the R.O. comes to the rescue, and there is compulsory treatment. So, although patients may not apply directly to mental out-patient departments, they should at least arrive there indirectly if the medical interns and general practitioners were more alive to symptoms of early mental breakdown.

The Commissioners note the progress being made generally in the establishment of mental out-patient departments. Some interesting developments in this direction have occurred at Oxford, Bethlem and the Middlesex Hospital, and are commended in the 1922 report. The existence of an out-patient department at the West Riding Mental Hospital for over thirty years is mentioned. We should like to add that Dr. Rayner started a like department at St. Thomas's Hospital about the same time, if not before, and also Dr. Percy Smith one at Charing Cross. A great advance was made when the Maudsley Hospital was inaugurated,and the experiences gathered there are likely to have a profound effect on the future of this movement. Dr. Mapother's first annual report is a document of absorbing interest, and the many practical details involved in the administration of a voluntary mental treatment system and the results of the first year's working thereof deserve greater notice than can be afforded here.

Infectious diseases.—Up to June 30, 1921, the Board had based its observations on the incidence of infectious diseases on mortality returns. The numbers dying from such cause were definite facts of some importance, but of course were no real guide as to incidence. Since that date, however, the Board have been receiving weekly returns of the actual occurrence of such diseases, and these, though not so reliable, when considered with the mortality returns now

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enable the Board to explore the situation in regard to these matters with some degree of certainty as to facts.

Of course, the value of these weekly returns depends entirely upon accurate diagnosis, and this is often one of great difficulty with the insane. As regards *tuberculosis*, some medical officers may be actuated mainly by prophylactic motive and include as tuberculous a great number of suspected cases. No doubt these are absorbed in the returns, and only deleted after prolonged observation, or on the appearance of another medical officer with greater respect for the purity of statistics. It should not be impossible for the Board to arrive at some standard of diagnosis of tuberculosis, or to have suspected cases returned separately. Neither cough nor sputum may be present, and the results of physical examination of the chest may be practically *nil*. Yet at the *post-mortem* very advanced tuberculosis of the lungs may be revealed. We have no doubt in our own minds that this accounts to some extent for the wide variation in the incidence of phthisis as revealed by the returns so far. It goes without saying that all cases of phthisis, whether suspected or undoubted, should be isolated. This again is a difficulty, unless there is a specially constructed sanatorium.

Another factor in the incidence of tuberculosis worthy of the Board's consideration is one revealed by a comparison of the mortality from this disease among the general population, and among patients in mental hospitals. The high incidence of tuberculosis as regards the latter is directly related to a high general death-rate. Mental hospitals with a low incidence of tuberculosis draw their patients from rural areas which include a number of non-industrial towns, and those with a high incidence from areas which include many towns of an industrial character. Thus one important factor of a high incidence of tuberculosis in mental hospitals may well be the general impaired physical condition of patients on admission.

It is gratifying to note that for 1923 there was a very satisfactory decline in the incidence and mortality of tuberculosis, the latter being the lowest for many years past.

The direct prophylactic measures against tuberculosis in mental hospitals we think most worthy of serious consideration are (1) rigid isolation of known and suspected cases; (2) periodic sterilization of walls, furniture, curtains, carpets, etc.; (3) the installation of vacuum cleaning; (4) failing the latter a careful attention to the time and mode of sweeping and dusting rooms; (5) the use of some form of antiseptic wax as a cleaning preparation for floors, furniture, door handles, etc. An experiment with the latter seems to be giving good results at one institution.

As regards *dysentery*, the report for 1923 also records a satisfactory reduction in both incidence and mortality, the former from 8·7 per 1,000 to 4·5 per 1,000. The incidence of severe diarrhœa also fell from 3·9 per 1,000 to 2·4 per 1,000. As regards the diagnosis of dysentery the position is not so difficult. The clinical features are very definite, and we think that those cases of severe diarrhœa with positive results on bacteriological examination should also be registered as dysentery. The record of the incidence of other cases

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of severe diarrhœa will be valuable until we know more about the ætiology of dysentery, which term possibly covers not one but several disorders of the colon.

Typhoid and paratyphoid.—We are glad to note that the Board, in their report for 1923, recognize that the grouping of these conditions as "enteric" is no longer desirable. By "enteric" most of us mean "typhoid." Both paratyphoid "A" and "B" are much less serious illnesses and rarely fatal. During the war it was discovered that a great proportion of those who were returned as "enterics" were suffering from paratyphoid, which cleared up the mystery as to why antityphoid inoculation had suddenly failed to give immunity. There appears to be no doubt that the presence of carriers is an important factor in the occurrence of these diseases, and this may answer the difficult question raised by the Board as to why the incidence in mental hospitals is preponderatingly greater among female nurses and patients than among male nurses and patients. Good work in systematically searching out carriers is in progress at some mental hospitals.

Erysipelas.—Any attempt to ascertain the incidence of this almost nebulous condition seems hopeless, and the Commissioners would do well to indicate exactly what they mean by this term. Septic infections are apt to spread if conditions are favourable, and it has not been unknown for every case dying in an infirmary ward for some months to show recent vegetations on the cardiac valves. In many cases of the so-called erysipelas, very careful examination reveals the place of entry of the septic organism, and prompt treatment at this point is followed by quick recovery.

Pneumonia.—Secondary and terminal pneumonias are so commonly found in those dying in mental hospitals from any illness lasting over a few weeks that their importance as a cause of death is very doubtful. Primary pneumonias, however, are on a different footing, and though the exact pathology of these conditions has yet to be defined, they are rightly included as notifiable diseases. The Board again emphasizes the point that at those institutions where the incidence of tuberculosis is most evident, dysentery, erysipelas and pneumonia follow suit. There might be wisdom in remembering that "seek and ye shall find" is very true of institutional medical work. This "seeking and finding" depends upon the strength of the medical staff and the encouragement given to clinico-pathological work. The advent to a mental hospital of a medical staff numerically and otherwise strong is sure to alter the complexion of returns and statistics, and understaffing in this respect does not necessarily mean greater incidence of diseases and a corresponding increase in the number of cases notified. Until our mental hospitals are above reproach in this matter, so long will statistics indicate tendencies rather than facts.

Death-rates in the general community compared with those in mental hospitals.—Some interesting pages of the 1923 report are devoted to a consideration of this subject. There is one point the Commissioners do not take into account in this comparison, and that is the comparatively few cases among the general population in which

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the cause of death is ascertained by *post-mortem* examination. The validity of the death returns regarding the general population is much impaired thereby. Strictly speaking the causes of death among the latter are only "apparent," while for the most part those of patients dying in mental hospitals are "ascertained." This particularly affects such causes of death as cancer and tuberculosis, where diagnosis is admittedly difficult and unreliable. Notwithstanding this, it is of considerable interest to be reminded at this time that the incidence of cancer is low in mental hospitals in comparison with that of the general population, and the Board think that this fact might be worthy of the attention of the Cancer Research Committee, and perhaps help to elucidate the still unsolved problem of its ætiology.

Encephalitis lethargica.—The Commissioners in their 1923 report note the advent of this disease to a position of some importance as a factor in the ætiology of mental infirmity. Prominence was given to this disease and its nervous sequelæ by several outbreaks during the past decade, and there can be no doubt that many of these cases found their way into mental institutions without their nature being recognized on admission. Medical officers are now on the look-out for them with a good chance of correct diagnosis. Past cases are being recognized and re-classified, a new light being shed on the prior history of a feverish or influenzal attack, with nervous prostration, giddiness, falling about, etc., and subsequent divers paralyses, both motor and sensory. We venture to think that there has been a greater accumulation of cases of encephalitis lethargica in mental hospitals than is usually imagined, and we are glad that the Board is giving some attention to the matter. So far no statistics as to the incidence of the admission of such cases to mental hospital care are available, and no case is recorded as dying during 1922 from this cause.

We learn from a paper by Dr. P. K. McCowan in the *Lancet* of February 7, 1925, that 12 cases from the London County mental hospitals have been segregated at the West Park Mental Hospital. The results of his preliminary study of these cases is reported, and his main conclusions are: (*a*) That certifiable insanity is extremely rare as a sequel of encephalitis lethargica; (*b*) many cases of insanity following upon this disease are not true sequelæ, the encephalitis merely acting as a precipitating psychic cause; (*c*) systematized delusions and dementia may characterize post-encephalitic psychoses; (*d*) psychotic symptoms during the acute phase of the disease are toxic in origin, and of much better prognosis than psychoses developing later. He also thinks that the virus of encephalitis lethargica may remain latent but potent after the acute symptoms have subsided.

There is no doubt, however, that the existence of this disease will have to be reckoned with in mental hospital practice for the future.

Mental Hospital Boards.—We are not, generally speaking, enamoured with the idea of the centralization of the administration of a group of mental hospitals under one management except for

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certain clearly defined purposes, like the pay and grading of staff, etc. Mental hospitals have traditions and aspirations which are individual to each, and the *esprit de corps* and emulation so helpful and even necessary to progress is apt to be lost when a hospital, hitherto a separate unit, is merged in a "service." The navigating of a fleet across the seas has, of necessity, to be at the speed of the slowest ship, and in the same way the benefits of co-operation are apt to be secured at the expense of initiative and progress.

The ideal government of a hospital is by a board of managers, with absolute control over all general administrative matters, and with considerable powers of initiative and experiment, but with a financial limit. The medical staff then know with whom they are dealing and are in personal contact with the managers. There is no delay in carrying out the business side of the hospital, and advance can be made in regard to medical administration, research and clinical work without reference, except consultation, to other hospitals. The principle underlying this has been at the root of the splendid progress made in medicine and surgery in the general hospitals, and should not be lost sight of when the management of several mental hospitals comes to be placed under one authority or board of managers.

The Commissioners note that the Staffordshire Asylums Act, 1922 came into operation on April 1, 1923, and called into being the third mental hospitals board, following the example of Lancashire and the West Riding of Yorkshire.

Finance.—We are always interested in the Commissioners' comments on finance and the cost of maintenance of public mental hospitals. While on the one hand they deplore a rising expenditure, as all self-respecting public authorities should, they are full of suggestions, most of which, if carried out, to say the least of them, would not lower the maintenance rate. They are able, however, to report a substantial decrease in the average weekly cost during each of the two years under review—£181,007 for 1922 and £606,977 for 1923. The cost of building and repairs has gone down also. This is the first turn of the tide for better or worse since 1911. The fall has been in commodities purchased generally, salaries and wages increased during 1921–22, and showed a substantial drop during 1922–23, due to the fall in the bonuses based on the cost of living. The cost of pensions, including those granted under the Lunacy Act of 1890, was $7\frac{5}{8}d.$ per head in 1922 and $8\frac{1}{8}d.$ per head in 1923.

General condition and progress.—The Board in 1923 reverted to its pre-war practice of publishing as an appendix to the annual report copies of the entries made in the visitors' book by Commissioners on their annual visitation to the mental institutions throughout England and Wales. We welcome this return to normal conditions, not only for the intrinsic merits of these entries, but also as possibly adumbrating the inclusion in future annual reports of some of the more important of the medico-psychological tables. Of the administrative tables the one most missed in actual administration is Table X—Miscellaneous Returns connected with the Care and Treatment, etc.

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The Commissioners are able to report substantial progress in many directions in care and treatment. The matters to which attention is drawn are classification, dietaries, personal hygiene, dental and other visiting specialists, general amenities and parole, clothing, objects of interest and amusement, and occupational treatment.

In our mind the more important of these matters are the appointment of adequate consulting staffs and occupational treatment.

Consulting staff or visiting specialists.—The future of good sound clinical work and the cure of mental disorders undoubtedly lies in properly organized team-work, especially as regards recent cases. Nothing impressed us so much in this respect as a perusal of Dr. Cotton's paper on "The Relation of Chronic Sepsis to the so-called Functional Mental Disorders," read before the Annual Meeting of the Association in July, 1923, and the discussion which followed. Perhaps the methodical investigation of cases impressed us more than the actual treatment advocated, though we formed a high opinion as to the possibilities of the latter. Also one great lesson of the war as regards medical treatment was the success of team work.

Much could be done in mental hospitals in this direction, provided there were adequate laboratory facilities, by the resident staff, but situated as they are, visiting specialists are an absolute necessity to that thorough investigation of the factors underlying the presence of mental abnormalities so essential to successful treatment.

The adoption of visiting specialists is a matter of relatively little cost, and delay in this matter means waiting for the costly establishment of mental clinics before any real progress can be made in the treatment of mental disorders.

Occupational treatment.—The Commissioners apparently refer to something allied to, but not identical with, occupational therapy as it is now generally understood. Occupation, especially useful occupation, is good for everybody, and especially for patients in mental hospitals who are mentally and physically capable. But occupational therapy must not be confused with vocational work, *i.e.*, the teaching of suitable occupations for the benefit of the patients both while in the hospital and on discharge. In an Occasional Note (January number, 1923, p. 95) we said: "Just as the disordered mind shows itself in disorders of behaviour, so it is thought that a restoration of behaviour or a re-education of muscle and volition may restore the intellectual and affective faculties." It is this finer occupational work that has come to the fore in recent years. The sole consideration is the psychic treatment of the patient. The occupation, its nature, the duration of effort, etc., are prescribed by the doctor just as he prescribes physic. Only patients incapable of concentration, or of giving attention, such as those suffering from states of confusion, mild stupor, restlessness, morbid introspection, etc., are eligible.

The so-called "able but unwilling" patients are excluded, and also of course those able and willing. A few of the latter, however, are useful as "decoys" or examples. Special classes are held for

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the worst cases in some central situation. Others less afflicted attend classes in the wards. The industrial side is of little or no importance. Certainly some of the things made are saleable, and the profits made may help to buy new materials. Even if there were no profits, experience shows that occupation therapy is, in many cases, good medicine, which is the important point. When capacity to work is sufficiently restored, then an officer of the character envisaged by the Commissioners can be very useful. True occupation therapy is not limited in application to recent cases; many chronic patients respond splendidly, and are put on the way to becoming useful workers. Even cases of terminal dementia can be re-educated, though the results are hardly worth the large expenditure of time and effort which is found necessary.

(*To be continued.*)

An Outline of Psychology. By WILLIAM MCDOUGALL, F.R.S. London: Methuen & Co., Ltd., 1923. Demy 8vo. Pp. xvi + 456. Price 12*s*.

In a previous number (July, 1923, p. 376) we announced the publication of this book, and from our preliminary survey of it we were led to state that it would go far to clear up the confusion created by the contentions of modern schools of psychology, and we still feel that in regard to many of the more important points of difference our statement is correct. The views of one who is, perhaps, the most outstanding figure to-day in the sphere of psychological research demand both our respect and serious consideration, and it is because Prof. McDougall's teachings on certain matters present points difficult of acceptance, and also because his book deals with issues of such vast importance, that we have felt compelled to postpone from time to time a review which ordinarily would have appeared in our pages long ago.

In 1905 Prof. McDougall published his *Primer of Physiological Psychology*. It deals with the fundamental relationship between neural and psychic processes, and may be considered as a classic. It is perhaps the best-read book on psychology that was ever published. It can be read over and over again and something illuminating discovered on every occasion. It is our business to read many psychological works—books, papers, pamphlets, etc.—and when thereby we are mystified and confused, which is not infrequent, we turn to this little primer and never fail to resume clear thinking. Some minor critics complain of the pontifical character of our author's utterances, but this is a virtue when contrasted with the incoherent thought and incomprehensibility which is a prominent feature of some psychological writers.

We are led to wonder whether the book we are now reviewing will come to have the same place in our regard as the primer referred to. It may do, but there is this difference. The primer deals with fundamental truths of a broad and comprehensive kind, and is

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